

CERTIFICATE OF MEDICAL NECESSITY		DMERC 07.02A
<b>SEAT LIFT MECHANISM</b>		
SECTION A      CERTIFICATION TYPE/DATE:    INITIAL <u>  </u> / <u>  </u> / <u>  </u> REVISED <u>  </u> / <u>  </u> / <u>  </u>		
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER  (    )                      HIC# <u>                    </u>		SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC NUMBER  (    )                      NSC# <u>                    </u>
PLACE OF SERVICE <u>                    </u> NAME AND ADDRESS OF FACULTY IF APPLICABLE (SEE REVERSE)	HCPCS CODE <u>                    </u> <u>                    </u> <u>                    </u>	PT DOB <u>  </u> / <u>  </u> / <u>  </u> ; SEX(M/F);    HT <u>  </u> (IN.);    WT <u>  </u> (LBS.) PHYSICIAN NAME, ADDRESS (PRINTED OR TYPED) PHYSICIAN'S UPIN: <u>                                    </u> PHYSICIAN'S TELEPHONE #: (    ) <u>                    </u>
SECTION B      INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES.		
EST. LENGTH OF NEED (# OF MONTHS): <u>      </u> 1-99 (99=LIFETIME)   DIAGNOSIS CODES (ICD-9): <u>      </u> <u>      </u> <u>      </u>		
ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (CIRCLE Y FOR YES, N FOR NO, OR D FOR DOES NOT APPLY)	
Y   N   D	1. DOES THE PATIENT HAVE SEVERE ARTHRITIS OF THE HIP OR KNEE?	
Y   N   D	2. DOES THE PATIENT HAVE A SEVERE NEUROMUSCULAR DISEASE?	
Y   N   D	3. IS THE PATIENT COMPLETELY INCAPABLE OF STANDING UP FROM A REGULAR ARMCHAIR OR ANY CHAIR IN HIS/HER HOME?	
Y   N   D	4. ONCE STANDING, DOES THE PATIENT HAVE THE ABILITY TO AMBULATE?	
Y   N   D	5. HAVE ALL APPROPRIATE THERAPEUTIC MODALITIES TO ENABLE THE PATIENT TO TRANSFER FROM A CHAIR TO A STANDING POSITION (E.G., MEDICATION, PHYSICAL THERAPY) BEEN TRIED AND FAILED? IF YES, THIS IS DOCUMENTED IN THE PATIENT'S MEDICAL RECORDS.	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (PLEASE PRINT): NAME: <u>                                    </u> TITLE: <u>                                    </u> EMPLOYER: <u>                                    </u>		
SECTION C      NARRATIVE DESCRIPTION OF EQUIPMENT AND COST		
(1) NARRATIVE DESCRIPTION OF ALL ITEMS, ACCESSORIES AND OPTIONS ORDERED; (2) SUPPLIER'S CHARGE; AND (3) MEDICARE FEE SCHEDULE ALLOWANCE FOR EACH ITEM, ACCESSORY, AND OPTION. (SEE INSTRUCTIONS ON BACK)		
SECTION D      PHYSICIAN ATTESTATION AND SIGNATURE/DATE		
I CERTIFY THAT I AM THE PHYSICIAN IDENTIFIED IN SECTION A OF THIS FORM. I HAVE RECEIVED SECTIONS A, B AND C OF THE CERTIFICATE OF MEDICAL NECESSITY (INCLUDING CHARGES FOR ITEMS ORDERED). ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO, HAS BEEN REVIEWED AND SIGNED BY ME. I CERTIFY THAT THE MEDICAL NECESSITY INFORMATION IN SECTION B IS TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY FALSIFICATION, EMISSION, OR CONCEALMENT OF MATERIAL FACT IN THAT SECTION MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.		
PHYSICIAN'S SIGNATURE <u>                                    </u>		DATE <u>  </u> / <u>  </u> / <u>  </u> (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FIG. 1

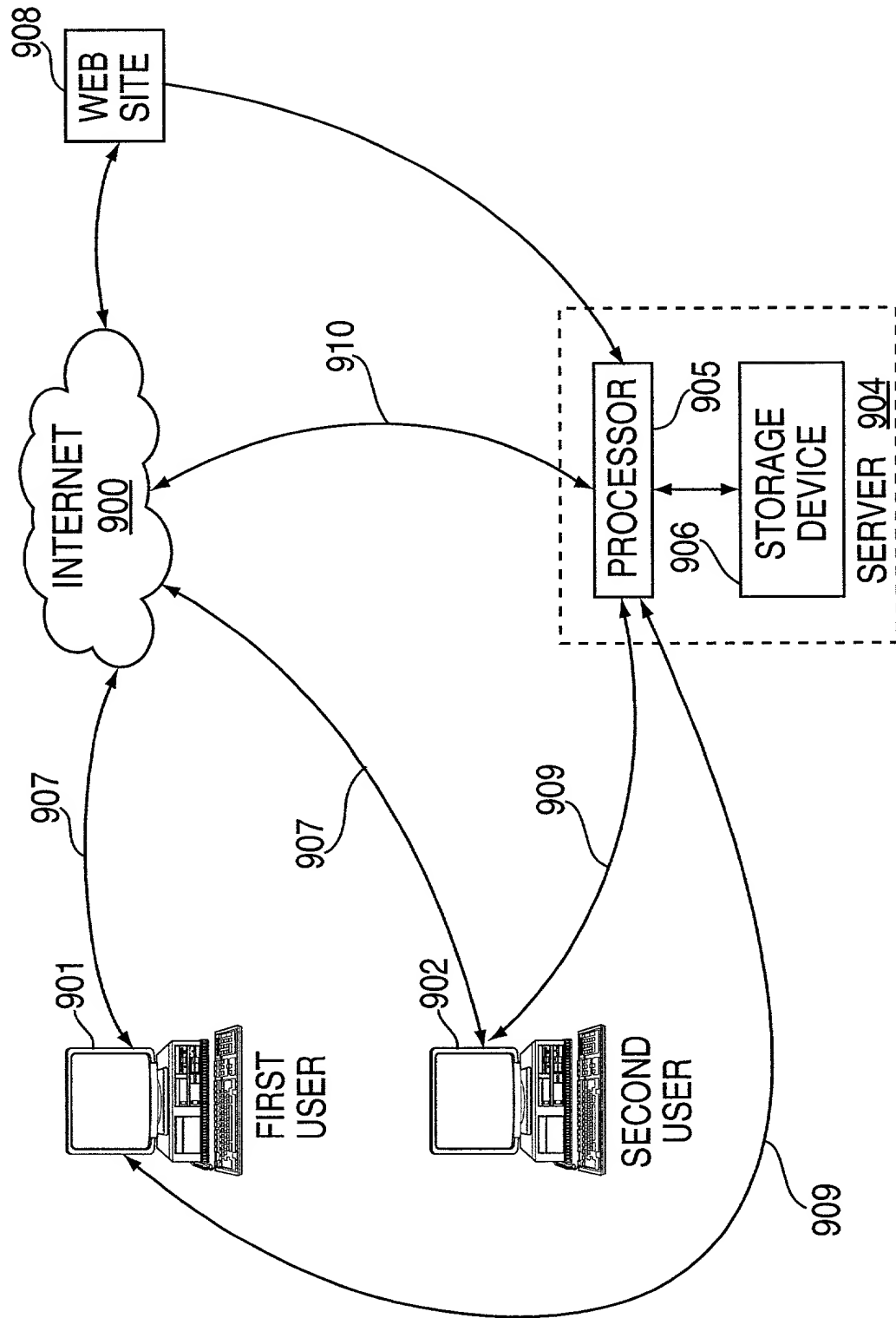


FIG. 2

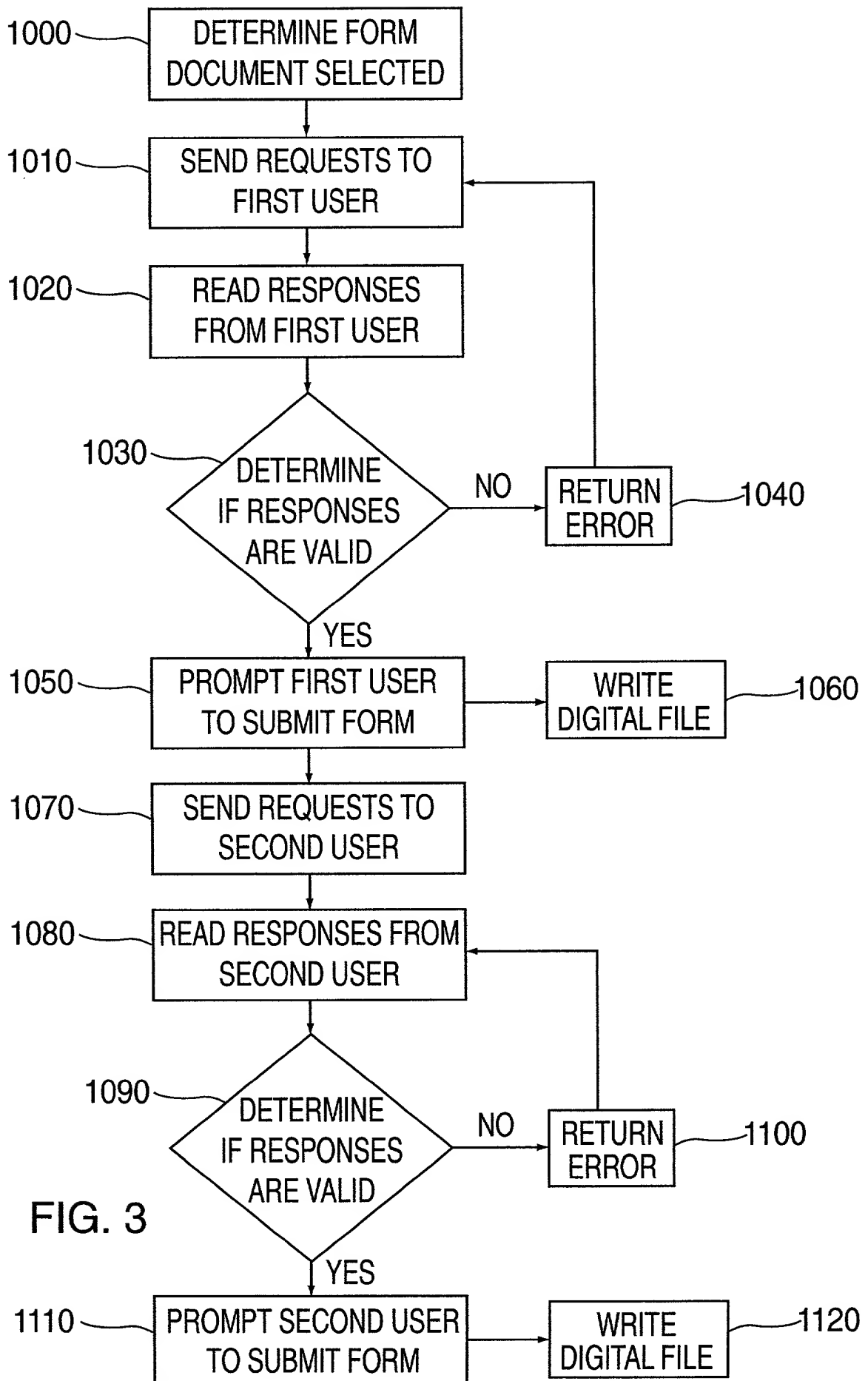


FIG. 3

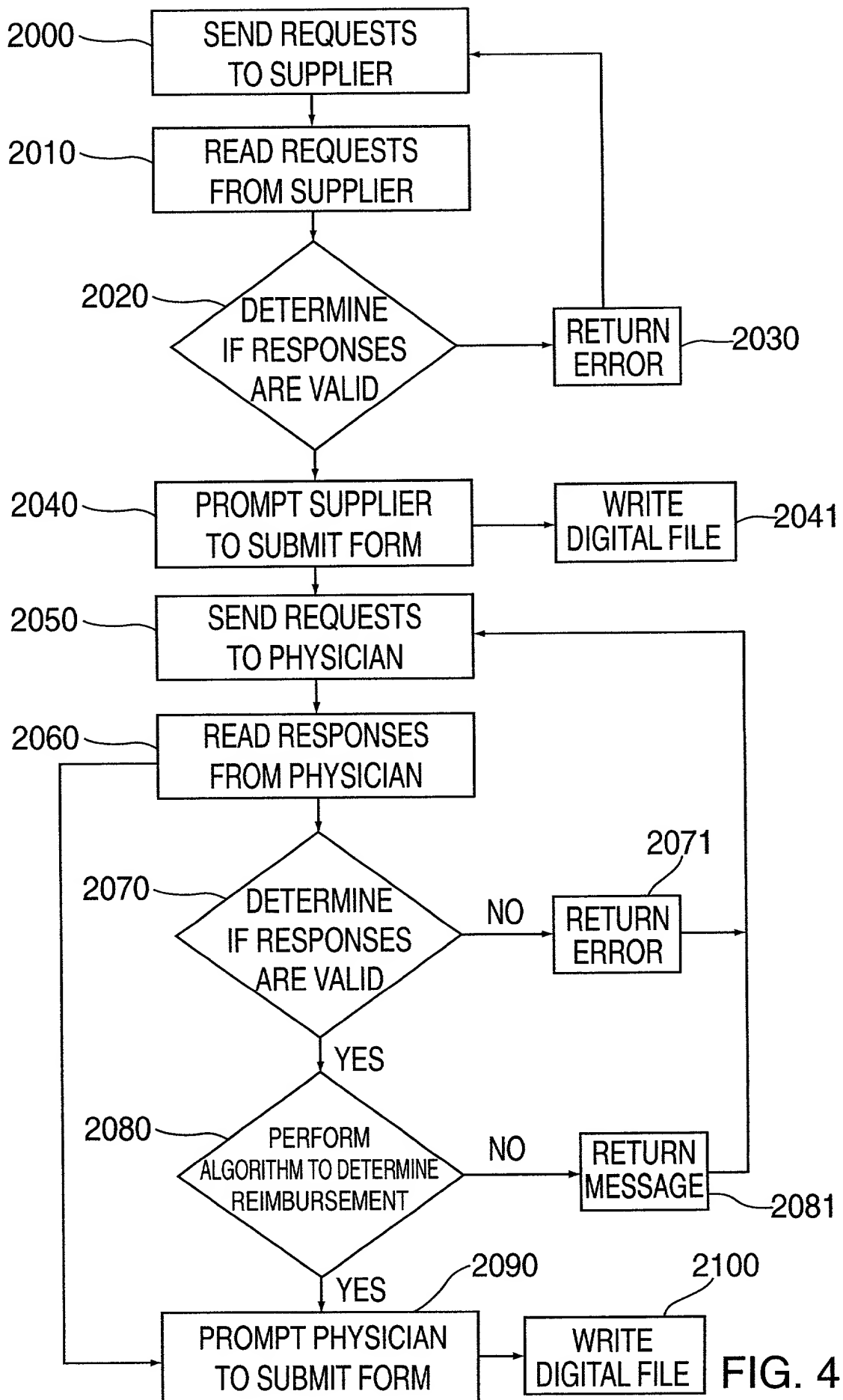


FIG. 4

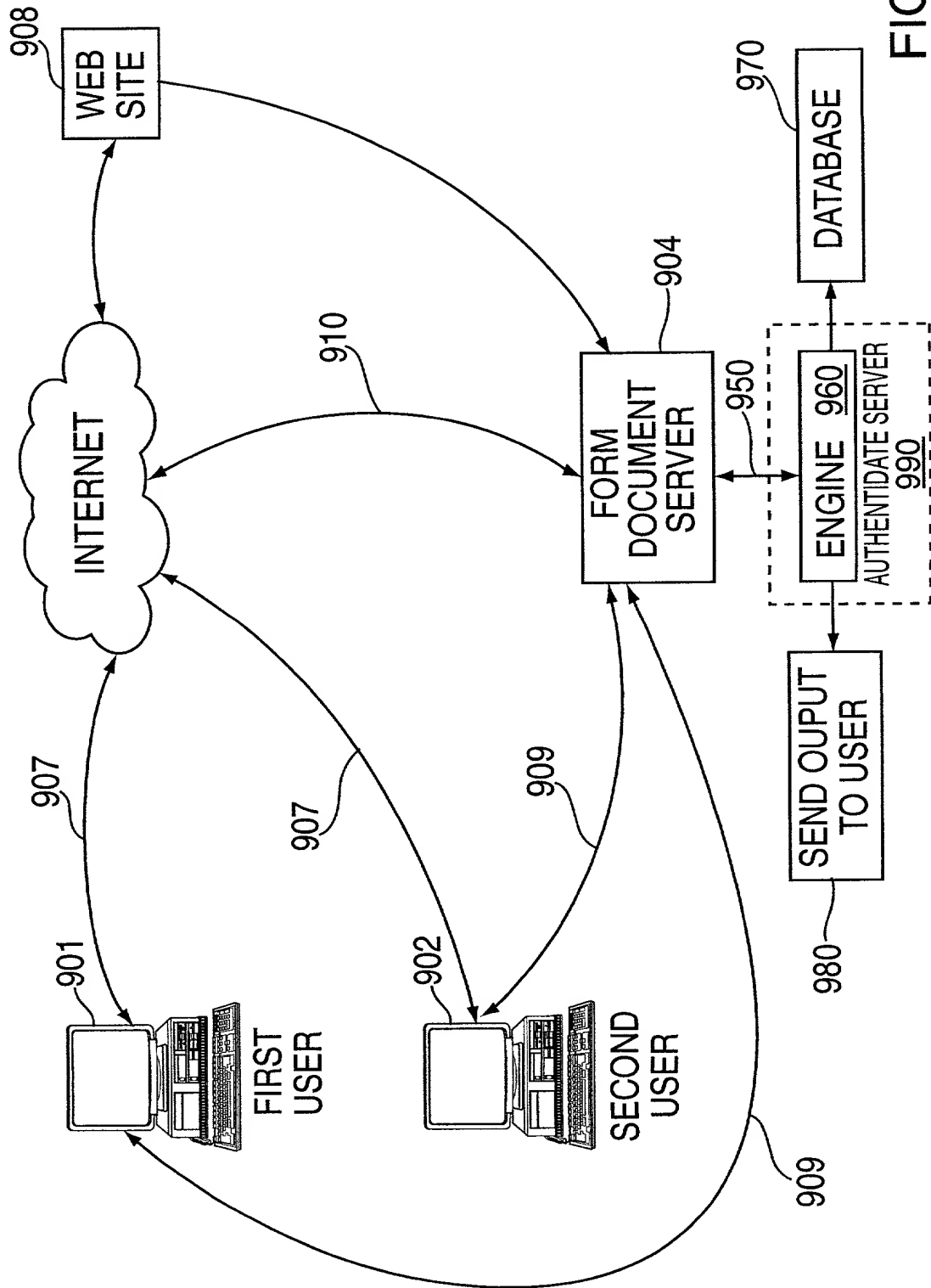


FIG. 5

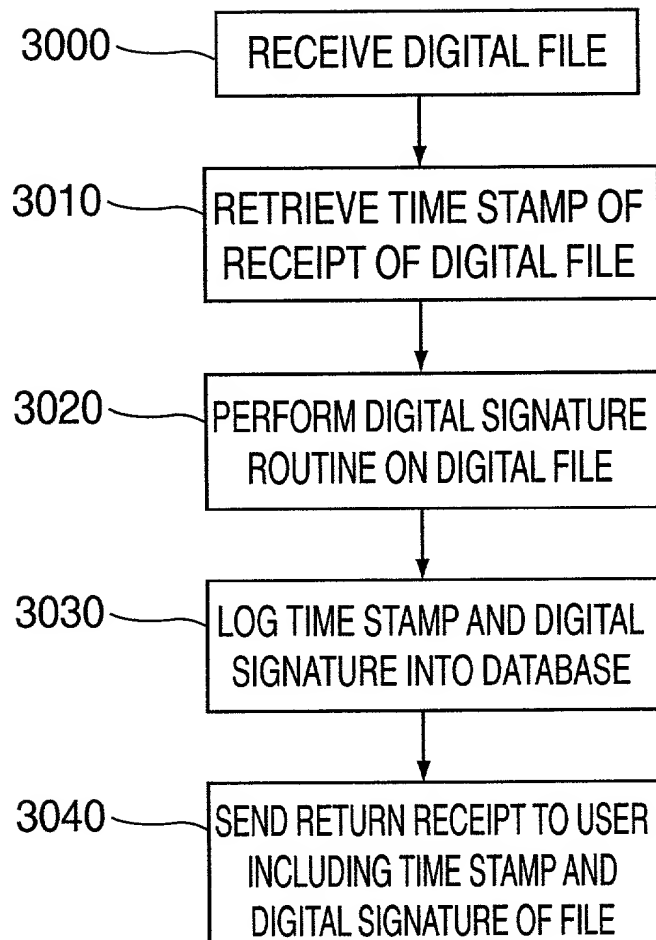


FIG. 6

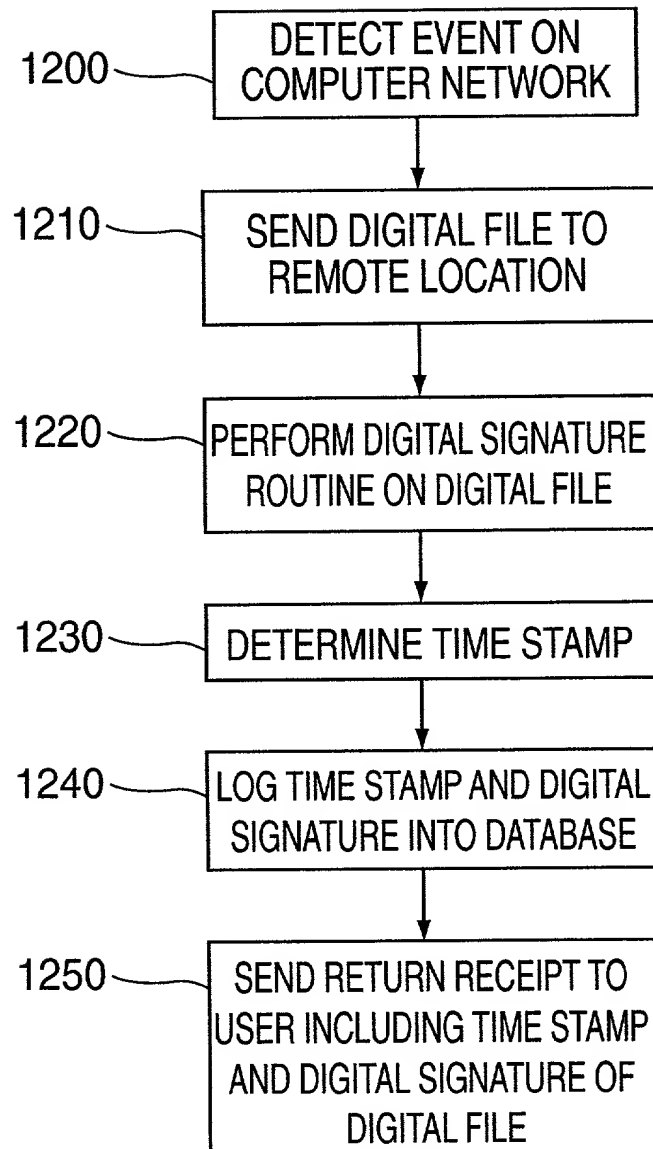


FIG. 7